

## INFORMED CONSENT FOR MEDICATION

Completion of this form is voluntary. If not completed, the medication cannot be administered without a court order unless in an emergency.  
This consent is maintained in the client's record and is accessible to authorized users.

Name – Patient / Client (Last, First MI)		ID Number	Living Unit	Birthdate
Name – Individual Preparing This Form		Name – Staff Contact		Name / Telephone Number – Institution
MEDICATION CATEGORY	MEDICATION	RECOMMENDED DAILY TOTAL DOSAGE RANGE		ANTICIPATED DOSAGE RANGE
Anti-seizure	Neurontin (gabapentin)	900 mg. – 3600 mg. Note special instructions when beginning dosage. Under age 12, dosage determined by physical		

The anticipated dosage range is to be individualized, may be above or below the recommended range but no medication will be administered without your informed and written consent.

Recommended daily total dosage range of manufacturer, as stated in Physician's Desk Reference (PDR) or another standard reference.

This medication will be administered ☐ Orally ☐ Injection ☐ Other – Specify:

**1. Reason for Use of Psychotropic Medication and Benefits Expected (note if this is 'Off Label' Use)**

Include DSM IV diagnosis or the diagnostic "working hypothesis".

**2. Alternative mode(s) of treatment other than or in addition to medications include (Check all that apply)**

Note: Some of these would be applicable only in an inpatient environment.

- |   |   |
|---|---|
| <input type="checkbox"/> Environment and / or staff changes         | <input type="checkbox"/> Rehabilitation treatments / therapy (OT, PT, AT) |
| <input type="checkbox"/> Positive redirection and staff interaction | <input type="checkbox"/> Treatment programs and approaches (habilitation) |
| <input type="checkbox"/> Individual and / or group therapy          | <input type="checkbox"/> Use of behavior intervention techniques          |

**Other Alternatives:**

**3. Probable consequences of NOT receiving the proposed medication are (Check all that apply)**

**Impairment of** ☐ Work Activities ☐ Family Relationships ☐ Social Functioning

**Possible increase in symptoms leading to potential**

- |  |  |
|--|--|
| <input type="checkbox"/> Use of seclusion or restraints              | <input type="checkbox"/> Limits on recreation and leisure activities |
| <input type="checkbox"/> Limits on access to possessions             | <input type="checkbox"/> Intervention of Law Enforcement             |
| <input type="checkbox"/> Limits on personal freedoms                 | <input type="checkbox"/> Risk of harm to self or others              |
| <input type="checkbox"/> Limit participation in treatment activities |  |

**Other consequences**

**Note:** These consequences may vary, depending upon whether or not the individual is in an inpatient setting. It is also possible that in unusual situations, little or no adverse consequences may occur if the medications are not administered.

4. Possible side effects, warnings and cautions associated with this medication are listed below. This is not an all inclusive list but is representative of items of potential clinical significance to you. For more information on this medication, you may consult further with your physician or refer to a standard text such as the PDR or the United States Pharmacopoeia Dispensing Information (USPDI). As part of monitoring some of these potential side effects, your physician may order laboratory or other tests. The treatment team will closely monitor individuals who are unable to readily communicate side effects, in order to enhance care and treatment.

Continued – Possible side effects, warnings and cautions associated with this medication.

The most common side effects include clumsiness or unsteadiness, continuous uncontrolled back and forth and / or eye movements, blurred or double vision, dizziness, drowsiness, muscle ache or pain, swelling of the hands, feet, or lower legs, trembling or shaking, decrease or absence of reflexes, unusual tiredness or weakness, pneumonia.

Less common side effects include depression; irritability or other mood or mental changes; loss of memory; diarrhea; dryness of the mouth or throat; frequent urination; headache, indigestion; low blood pressure; nausea; noise in the ears or hearing problems; runny nose; slurred speech; trouble in thinking; trouble in sleeping, abnormal dreams; weakness or loss of strength; weight gain; chest pain; palpitations; anemia.

Rare but potentially serious side effects include fever or chills; cough or hoarseness; lower back or side pain; painful or difficult urination.

**CAUTION** – This medication has the potential to impair judgment, thinking, or motor skills. Be cautious about operating hazardous machinery including automobiles until reasonably certain that therapy with this medication does not affect you. Notify your physician if you become pregnant or intend to become pregnant. Do not breast feed an infant until you have discussed this with your physician.

**WARNING** – This medication will add to the effects of alcohol and other CNS depressants (slow down the nervous system, possibly causing drowsiness). Some examples of CNS depressants are antihistamines or medicine for hay fever, other allergies, colds; sedatives, tranquilizers or sleeping medicine; prescription pain medicine or narcotic; barbiturates; other medicines for seizures; muscle relaxants; anesthetics, including dental anesthetics.

See PDR, USPDI or American Hospital Formulary Service for all-inclusive list of side effects.

**By my signature below, I GIVE consent for the named medication on Page 1 and anticipated dosage range. My signature also indicates that I understand the following:**

1. I can refuse to give consent or can withdraw my consent at any time with written notification to the institution director or designee. This will not affect my right to change my decision at a later date. If I withdraw consent after a medication is started, I realize that the medication may not be discontinued immediately. Rather it will be tapered as rapidly as medically safe and then discontinued so as to prevent an adverse medical consequence, such as seizures, due to rapid medication withdrawal.
2. Questions regarding this medication can be discussed with the Interdisciplinary Team, including the physician. The staff contact person can assist in making any necessary arrangements.
3. Questions regarding any behavior support plan or behavior intervention plan, which correspond with the use of the medication, can be directed to the client's social worker, case manager or psychologist.
4. I have the right to request a review at any time of my record, pursuant to ss. 51.30(4)(d) or 51.30(5)(b).
5. I have a legal right to file a complaint if I feel that client rights have been inappropriately restricted. The client's social worker, case manager or agency / facility client rights specialist may be contacted for assistance.
6. My consent permits the dose to be changed within the **anticipated dosage range** without signing another consent.
7. I understand the reasons for the use of the medication, its potential risks and benefits, other alternative treatment(s) and the probable consequences, which may occur if the proposed medication is not given.
8. This medication consent is for a period effective immediately and not to exceed fifteen (15) months from the date of my signature. The need for and continued use of this medication will be reviewed at least quarterly by the Interdisciplinary Team. The goal, on behalf of the client, will be to arrive at and maintain the client at the minimum effective dose.

#### SIGNATURES

#### DATE SIGNED

Client – If Presumed Competent to Consent / Parent of Minor / Guardian	Relationship to Client <input type="checkbox"/> Self <input type="checkbox"/> Parent <input type="checkbox"/> Guardian	
Staff Present at Oral Discussion	Title	

Client / Parent of Minor / Guardian Comments